DuPage Medical Group
CARDIOLOGY

STRONG HEART SMART HEART

Nuclear Cardiology Accredited Nuclear Cardiology Laboratory

ICAEL Accredited Echocardiography Laboratory

## Clinical Assessment

Home Phone Number (_____) _____

Work Phone Number (_____) _____

Primary Physician: _____

Referring Cardiologist: _____

Place Identification Label Here

History Obtained from: ☐ Patient ☐ Family ☐ Hospital Records ☐ Transfer Records
☐ Other _____

Major (Chief) Complaint: _____

Past Medical History:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

| Cardiovascular History | Associated Signs/Symptoms | Risk Factors |
|---|---|---|
| ☐ Heart Murmur | ☐ Dizziness on standing | ☐ High Blood Pressure |
| ☐ Stroke/TIA | ☐ Shortness of breath with activity | ☐ Diabetes |
| When? _____ | ☐ Awakening from sleep with | ☐ High Cholesterol |
| ☐ Rheumatic Fever | shortness of breath | ☐ Minimal Exercise |
| ☐ Peripheral Vascular Disease | ☐ Swelling of the ankles | ☐ Family history of heart disease |
| ☐ Pulmonary Embolus/Blood Clots | ☐ Sleeps with greater than 2 pillows | ☐ Post-menopausal/not on estrogen |
| When? _____ | ☐ Palpitations | (Natural/Surgical) |
| ☐ Bypass Surgery | ☐ Passing out spells | ☐ Smoking _____Packs/Day |
| When? _____ | ☐ Pain in legs when walking | Years _____ |
| ☐ Angioplasty | ☐ Chest pain | Quit _____ |
| When? _____ | | ☐ Overweight |
| ☐ Congestive Heart Failure | | |
| ☐ Pacemaker/Defibrillator | | |
| When? _____ | | |
| ☐ Heart Attack | | |
| When? _____ | | |
| ☐ NONE OF THE ABOVE | ☐ NONE OF THE ABOVE | ☐ NONE OF THE ABOVE |

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Social History: ☐ Married ☐ Single ☐ Significant Other ☐ Divorced

Health Status of significant other: _____

Children: _____

Health Status of Children: _____

Occupation: _____

| Consume Alcohol | Drug Use | Tobacco Use | Caffeine Use |
|---|---|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| How Often? _____ | How Often? _____ | How Often? _____ | How Often? _____ |
| _____ | _____ | _____ | _____ |

## REVIEW OF SYSTEMS

In General:
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Cancer
- ☐ Anesthetic reaction
- ☐ Night Sweats
- ☐ None

Eyes:
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other_____
- ☐ None

Ears, Nose, Throat:
- ☐ Deafness
- ☐ Vertigo/Dizziness
- ☐ Ringing on ears
- ☐ Other_____
- ☐ None

Skin:
- ☐ Skin rash
- ☐ Other_____
- ☐ None

Musculoskeletal:
- ☐ Arthritis
- ☐ Amputation
- ☐ Gout
- ☐ Back pain
- ☐ Other_____
- ☐ None

Psychiatric:
- ☐ Depression
- ☐ Other_____
- ☐ None

GI:
- ☐ Hiatal hernia
- ☐ Ulcers/bleeding from gastrointestinal tract
- ☐ Hepatitis
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Constipation
- ☐ Acid reflux
- ☐ Other_____
- ☐ None

Hematology:
- ☐ Easy bleeding
- ☐ Blood transfusions
- ☐ None

Renal:
- ☐ Prostate
- ☐ Kidney dysfunction
- ☐ Incontinence/loss of urine
- ☐ Kidney stones
- ☐ Urinary tract infections
- ☐ Other_____
- ☐ None

Allergies & Immunology:
- ☐ Immune disorder
- ☐ Other_____
- ☐ None

Respiratory:
- ☐ Sleep apnea/breathing stops while sleeping
- ☐ Snoring
- ☐ Emphysema
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ None

Glandular/Endocrine:
- ☐ Thyroid
- ☐ Uric acid
- ☐ Other_____
- ☐ None

Neurological:
- ☐ Tremors
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ None

☐ ALL OTHER SYSTEMS NEGATIVE

Comments on all check items:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Past Surgeries/Significant Illnesses: | Date: | MD/Hospital:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication (please include over the counter and vitamins) | Dosage per day

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies/Intolerances _____

_____

_____

Allergic to X-Ray dye ☐ Yes ☐ No ☐ Unknown

| Family History | Illnesses | Deceased | Living |
|---|---|---|---|
| Mother: | | | |
| Father: | | | |
| Brother: | | | |
| Brother: | | | |
| Sister: | | | |
| Sister: | | | |

Signature _____